Protocol for Work in Support of the State Innovation Model Medicaid Quality Improvement and Shared Savings Program

For purposes of outlining scope and sequence of the work of the Medical Assistance Program Oversight Council (MAPOC) Care Management Committee in furthering work associated with the State Innovation Model (SIM) initiative, SIM Project Management (PMO) and the Department of Social Services (DSS) jointly affirm the following:

- The PMO and DSS recognize the inter-relationship of the Medicaid Quality Improvement and Shared Savings Program (QISSP) and the SIM initiative and agree that the planning process should be aligned.
- DSS is responsible under statute to report to and seek review and comment from the MAPOC and its associated committees. MAPOC leadership has identified its Care Management Committee (the Committee) as the lead entity for providing review and comment to DSS on development of its QISSP program under SIM. The Care Management Committee includes longstanding membership as well as new representation by SIM Steering Committee and Consumer Advisory Board members, as well as the Director of the SIM PMO. The Committee will review and provide comment to DSS on all aspects of QISSP, including, but not limited to, development of 1) standards for the Request for Proposals through which DSS will seek qualified entities; 2) timing of issuance of the RFP; 3) method by which beneficiaries will be attributed; 4) means of ensuring beneficiary protections and assessing whether desired outcomes have been achieved; and 5) shared savings methodology.
- SIM is an all-payer initiative, which seeks to maximize the alignment of all payers around common goals and methods of care delivery and payment reform. SIM has established a governance structure that includes representation of state agencies, consumer advocates, payers, and providers. This structure is intended to support all-payer alignment. In the interest of promoting integrated planning, the MAPOC has included representatives of the SIM governance structure on its Care Management Committee. Further, MAPOC has agreed to recommend up to two MAPOC representatives for participation on each committee, board or council that is part of the SIM governance structure.
- DSS is the single state Medicaid agency for Connecticut. Consistent with federal law, DSS' primary obligation is to promote and safeguard the interests of Medicaid beneficiaries. DSS acknowledges and supports the role that the Medicaid program will play in achieving the goals of the SIM initiative. These goals include continuous improvement of health, quality and equity in healthcare, and affordability for all citizens

of Connecticut. DSS retains authority to participate in the SIM initiative in the manner that it determines to be in the best interest of Medicaid beneficiaries.

- SIM has an interest and principal role in convening stakeholders to develop a comprehensive set of quality measures, as well as a range of strategies that will safeguard beneficiaries from being denied care or receiving reduced care, both of which are intended to be endorsed by all Connecticut payers.

- The SIM Quality Council and Equity & Access Council have been charged with convening all Connecticut payers to make recommendations that are responsive to the needs and interests of all payers and all populations.

- The Quality Council includes representation from a range of state agencies, consumer advocates, health plans and providers, as well as MAPOC representation.

- For the purposes of integrating DSS' and the Committee's work on QISSP quality measures with the work of the Quality Council, DSS will work directly with a workgroup of the Committee to develop a supplemental quality measure set that addresses the special needs of Medicaid beneficiaries. The workgroup will share its recommendations with the Care Management Committee for its review and comment. DSS will then present the recommendations of the Care Management Committee to the Quality Council through the Medicaid Medical Director and the Quality Council will consider including these recommendations in the package of measures that will be endorsed by all Connecticut payers. No matter what the result of the above process, DSS will retain authority to implement the measures that it determines to be in the best interest of the Medicaid program.

- The Equity and Access Council membership includes representation from a range of state agencies, consumer advocates, health plans and providers. The MAPOC has appointed two representatives to the Council.

- The SIM PMO is contracting with a consultant to provide facilitative and subject matter support for the Equity and Access Council. The consultant will play a significant role in preparing a report that outlines a comprehensive package of proposed safeguards including methods for monitoring and addressing under-service. The report will include recommended safeguards for the general population, as well as supplementary safeguards that may be required only for the Medicaid population.

- For the purposes of integrating DSS and the Committee's processes for developing QISSP under-service measures with the process of the Equity & Access Council, DSS will work directly with a workgroup of the Care Management Committee to develop strategies to address and safeguard against under-service that address the special needs of Medicaid beneficiaries. DSS and the workgroup will meet with the consultant engaged by the SIM PMO. The workgroup will share its recommendations with the Care Management Committee for its review and comment. DSS will convey the recommendations of the Care Management Committee to the Equity & Access Council

through the Medicaid Director and the Equity & Access Council will consider including these measures in its recommendations. The goal of the Equity & Access Council is to recommend a set of strategies (e.g. quality measures, audit, other means) through which to safeguard beneficiaries of all payers from underservice. No matter what the result of the above process, DSS will retain authority to implement the measures that it determines to be in the best interest of the Medicaid program.